Health Home Quality Improvement Workgroup - 4/27/2022

Participants

Pamela Lester IME	**Heidi Weaver IME**	LeAnn Moskowitz IME
Tami Lichtenberg IME	**David Klinkenborg AGP**	**Sara Hackbart AGP**
Tori Reicherts ITC	**Bill Ocker ITC**	Flora Schmidt IBHA
Susan Seehase IACP	**Kristi Oliver Children's Coalition**	Paula Motsinger IME
Stacy Nelson Waubonsie	**Amy May Waubonsie**	Geri Derner YSS
Jen Cross Orchard Place (90min)	Kim Keleher Plains	**Andrea Lietz Plains**
Melissa Ahrens CSA	**Christina Smith CSA**	**Faith Houseman Hillcrest**
Ashley Deason Tanager	Stephanie Millard First Resources	**Kristine Karminski Abbe**
Shawna Kalous Plains	**Rich Whitaker Vera French (90min)**	Jamie Nowlin Vera French
Crystal Hall Tanager	Brooke Johnson Abbe	Mike Hines Tanager
Karen Hyatt DHS	Ericka Carpenter Vera French	**Kelsey Poulsen Tanager**

Notes

Last meeting Notes:

- No questions/concerns from group.

Reviewed topics discussed during last Meeting

- Any changes or questions from the group?
  - No response

Draft Workgroup Report:

- No questions/concerns from group.

Overview of the Timeline

- Timeline has been updated - please review
- Ask of you - we would like to add a few more meetings, extending past our original timeline. We would like to spend some time digging into and developing recommendations with who does what for each HH service.
  - Group agrees
  - Pam to add an additional meeting or two to our meeting series

Provider Standards: **Brainstorming Activity:**

- **HIT (Health Information Technology) (Slides 12-17):**
    - **Information from is also in the Federal Guidance Document (slide 12)**
    - **Any questions on guidance from the federal level? (slide 13)**
        - Kristine Karminski - is there a requirement needing to be in the SPA for HIT tied to each core service or can it be more broad?
            - Pam - both, we have it put in the provider standards and within each HH service
            - Kristine Karminski - in the SPA there are references to the lead entity and HIT but in other sections HIT refers more to the HH. For the core services can it more focused on Lead entity and not the IHH? Or does it have to be both?
                - Pam - The model in which HIT us used/incorporated is very different. Will be asking what does this look like and what are your recommendations. Assume you have your own HIT processes.
                - Today, our focus is more broad, and what the Lead Entity and HH need. How to grow and change with the technology.
    - **SMDL = State Medicaid Director Letter (slide 14)**
    - **West Virginia WV Health Homes (slide 15)**
            - What your thoughts on West Virginia?
                - Christina Smith - like the flexibility
    - **Minnesota (slide 16)**
            - Pam - There are some registries that can pull directly from your EHR and pull reports for gaps in care.
            - Richard Whitaker - There are some population heath modules with in EHRs. Makes sense to have some interface between data. It's important to make sure you know what data is being pulled into the registry. There needs to be transparency between the provider and who is managing the registry. It's the responsibility of the IHH to maintain integrity of the PHI.
            - Pam - all of the disease registries that I have seen have been with the provider
            - Karen Hyatt - is this for every member? Not all data is shared with the Peer and Family Peer Support Specialists.
                - Pam - yes, all internal team members, including not only the IHH but sharing with other providers. Including disease registry that is within your EHR or is outside of your HER.
                - Andrea Lietz - ITC has been awesome regarding disease registry for performance measures, they include subcategories and can send the IHH those lists. Assume AGP has this as well. This has been beneficial to piggyback on.

        - Sara Hackbart- we have gaps in care reports that show cohorts or info by the member for those measures.
        - Pam - gaps in care are not based on disease registry, they are based on missed opportunities in claims. Those are evidence-based practices and are not all inclusive of all gaps in care. Hope is that your disease registry can close those gaps in cares and get to a place where the gaps in care report is not helpful.
        - Richard Whitaker - gap in care reports - understand best practice, just knowing with where the gaps are. Hope that Iowa can take it a step further, more of the clinical insights that data can provide. What is working with similar cohorts and suggested strategies and not just who is not getting a service that should be but more of best clinical practice strategies (coming from the data). Patient registry is not just gaps in care but providing us actionable insights.
            - Pam - evidence-based guidelines - discussed this at last meeting. Disease registries that she has seen are with the provider not with the payer. The MCO has claims based information, the IHH has the clinical information.
- **What do you think is important to include in the SPA?**
    - Richard Whitaker - there are some providers that will struggle to provide the level of registry tool needed in their EHR. Will there be some help from the State? Technical assistance? There is varying ability with each EHR.
        - Pam - will take this question back
        - Christina Smith - can put that as part of the language that this is part of a journey, because couldn't do that today. Those transitions take a long time. Takes a lot of administrative support that is not a part of the program. Since there really isn't admin support built into the program. Very costly.
            - Faith Housman - I agree with what Christina is stating, as far as a journey and where we hope to go as it is important for IHH's to be aware of this especially in regards to EHRs. Our current EHR can't pull out the data we need so we are looking/vetting other EHR's
        - Kristine Karminski - keep it more broad - registry may not be tied to the EHR. Agencies have different ways of doing this, may have a way to have a registry and look at the gaps in care without having it in their EHR.

- **South Dakota (slide 17)**
  - Any other recommendations on HIT?
    - No response from the group
- **Pam - You have the ability to look at any other state SPA you would like to. West Virginia, Minnesota, and South Dakota are just a few examples we have provided.**
  - Link to State SPAs: https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/hh-spa-overview.pdf
- **Recap:**
  - The ask is:
    - Funding for technical assistance with using HIT, including where we want to go and how long it will take to get to a specific place, maybe use WV verbiage " As the use of HIT and the implementation of a statewide health information exchange evolve, it is anticipated that the use of HIT to support all of the health homes services will also evolve."
      - Christina Smith - To vet a new EMR and implement it and have it running can take at least a year
      - Richard- one year to get installed, technical assistance will need to be ongoing. Believe it is a two-year assistance. Give an organization runway to get there. 8-12 months to get things installed.
      - Christina Smith: correct Rich, you would need to give organizations at least 2 years minimum. There is a time where they have to decide if they need to make a change, which also could take 6 months, so maybe even longer
    - Keep patent registry vague

- **ICM (Intensive Care Management) (Slides 18-19):**
  - Kristine Karminski – in payment methodology of the SPA, chapter 90 is referenced but there are other chapters that are followed for this population. An example is a chapter that describes care coordination requirements for Hab/CMH. Is there anything in the application for a new IHH that identifies this expectation?
    - Sara Hackbart – Amerigroup has the new Health Home sign a pre-delegation agreement and submit their policies and procedures for review before they are enrolled as a provider.
    - Pam Lester – We can discuss this chapter when we talk about Provider Qualifications.
  - Health Home? – If OIG were to come back and review, what would they be looking for?

        - Pam Lester – I am not sure if their focus would change if they returned but when they did review us, they looked to see if the documentation for the specific ICM claim met the ICM requirements. I could tell the member had ICM level of care (in the specific chart I remember) because the member's documented habilitation provider. They clawed back the difference between the ICM and non-ICM rate.
    - Richard and Christina both agreed that this should be vague in the SPA.

- **Payment Methodologies (slides 20 - 24) Brainstorming Activity:**
    - **Caseload Assumptions (slide 21)**
        - Pam - not here to tell you what your staffing model should look like. There is not a preferred case load that works for everyone.
    - **Integrated Health Home Wages (slide 23)**
        - Anyone play around with this? https://www.iowaworkforcedevelopment.gov/iowa-wage-report
            - No response from group
    - **Rate Considerations from Survey (Slide 24)**
        - Richard Whitaker - Feel strongly about this issue. One thing missing. Size of IHH matters a lot. A IHH with 500 members vs. one with 1,500 members differs in the economies of scale. Challenges with staffing. For IHHs with smaller number of members its harder to manage that team.
        - Christina Smith - this is a numbers game. Some glaring things are missing. The way the program is designed, it is extremely administrative heavy. Built as if the admin piece is an add on. That is not necessarily how IHHs are doing it. Who is doing the data analytics and billing? When you budget this, you need basic administration for this. For every role, it lowers what they can pay them. Margin is so tight. Have not allowed any administration pieces. For smaller IHHs there is no way to do that. Challenges with not allowed quality assurance built into the program. The most administrative heavy program ever seen.
        - Melissa Ahrens- agree with rate consideration. Risk of members - very much impacting the rules and team members. Lots of members we are providing additional support to keep them stable as possible. That list has grown a lot over time.
        - Kristine Karminski - agree with what others are saying. Adding quality but not necessary wages. Not necessary around pop health. Its more about administrative burden.
        - Faith Housman - Very valid points - agree
        - Jennifer Cross - I agree, good points made!
        - Kristie Oliver - I agree also these are very valid points that need to be considered.

- Melissa Ahrens -reviewed states - going back to our discussion in previous meetings regarding exceptions for care coordinator that didn't meet the education criteria currently outlined in the SPA. Potentially utilizing staff that may not have the specific degree but have it in business, for example.
    - Faith Housman - If we look at trying to utilize staff to the fullest of their licensure, the administrative burden does not allow that.
- Pam- Documentation is part of the Health Home Service and is not considered administrative. Is the administrative burden outside of the documentation of the HH service?
    - Christina Smith - we have had to add 1 FTE around billing because the process is so complex. Issue is across all MCOs. When MCO systems are updated, it impacts them.
        - Bill Ocker - let please let me and Tori know of those situations
- Pam - issue with 99490 since it is a Medicare code for Chronic Care Management. One of the fixes to this is not using 99490 but something else. Thoughts?
    - Christine Smith - will help with some of the denials. Would have to talk to billers to see how it may impact. The code is often paid with the wrong rate also. Everyone at ITC in the upper management should know- we have talked many times
    - Shawna Kalous - in the long run it may provide a better solution, but could be traumatic in the short term
    - Kristine Karminski - need to take this back to discuss. Can the MCOs provide information that would give us use alternatives? What are the MCOs capabilities? Get denials for two services on one day. Get these pretty frequently.
        - Bill Ocker - usually not denied but paid at Medicare rate
        - Sara Hackbart- agree, AGP is seeing the same thing. Using our provider experience team works through those. Reach out to me if you would like additional assistance as well.
- Follow up:
    - If we changed the 99490 code, it would help eliminate the denials. Need to know from the MCOs what code instead would cause the least disruption?
        - Will bring back in two weeks.
        - Dave Klinkenborg - Suggest taking this to the claims and benefits meeting. Would want the state to drive this. Maybe a regulatory request.
            - Pam to send a request to add the topic to the claims and benefits meeting agenda.

- Kristine Karminski - its burdensome getting all cores services provided on the claim. Must manually add the additional service codes to the claim. Is it a CMS requirement to have all of the HH services on the claim?
    - Pam - that is difficult to answer. That was an outcome of the OIG audit.
- Christina Smith - agree that the actual billing process is burdensome. With EHRs have to pay to have integration. The way IHH billing has to be set up is really strange.

Next steps:

- We will be discussing the following at our next meeting, please review and be ready to provide your feedback:
    - Billing Burden
        - Including outcomes from internal discussions regarding changing the 99490 code.
        - Informational code recommendations.
    - Building the PMPM
    - Provider qualifications
    - Member Qualifications